A Canadian doctor in Zaire

Jim Lavery

Résumé : Plusieurs médecins canadiens travaillent pour un organisme de secours international, Médecins Sans frontières (MSF), pour offrir des soins de santé aux personnes qui en ont le plus besoin. Par exemple, l'an dernier, le Dr Michael Cain de Peterborough (Ont.) s'est rendu dans un pays d'Afrique centrale, le Burundi, pour traiter 5 000 réfugiés qui habitent un pays lointain, le Zaïre. Huit médecins canadiens travaillent actuellement avec MSF, mais ce nombre devrait augmenter à mesure que l'organisme se fait mieux connaître.

Last September, Dr. Michael Cain of Peterborough, Ont., and a team of medical workers met in a nondescript office in Bujumbura, Burundi. They wanted to develop a strategy to contain the rapid growth in the incidence of meningitis in the northwest region of the Central African country, and to organize a vaccination program for some 5000 Burundian refugees living in neighbouring Zaire who were soon to be repatriated to the affected region.

Cain and most of the meeting's other participants were working in the tiny central African country under the auspices of an international medical relief organization, Médecins Sans Frontières/Doctors Without Borders (MSF). (Today, Cain is working in nearby Rwanda.)

Throughout its 20-year history, MSF has earned an enviable reputation for its work with populations in danger; it specializes in handling situations involving war, disaster and refugees. Although this is Cain's first contract with MSF, he is no stranger to international health issues. Jos Nolle, the president of MSF Canada, describes Cain as "the type of doctor you can drop in the jungle with a box of medicine and pick up a year later."

Fourteen years of experience in locations such as Papua New Guinea, Ethiopia, Kenya and Guyana, and his proven ability to function independently, have made Cain an ideal candidate for his current MSF position.

In Bujumbura, the MSF team and some local workers reviewed health reports from 11 of Burundi's 15 provinces. From September to November of last year, there were 1300 reported cases of meningitis that resulted in 217 deaths. Those numbers are considered conservative estimates because of the lack of a reliable system of patient registration in rural areas. In addition, the rural dispensaries that serve most Burundians lack the medical personnel or testing techniques needed to accurately diagnosis meningitis.

For Cain and the MSF team, the lack of reliable data was the first in a series of challenges that made

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the development of an effective intervention strategy difficult. Even though an adequate information base was lacking, there was growing pressure on local health authorities and MSF to take action to arrest the spread of the epidemic. The pressure also grew because of the late onset of the rainy season last year. The rains usually begin in mid-September and, for reasons that are poorly understood, result in a significant reduction in the number of meningitis cases.

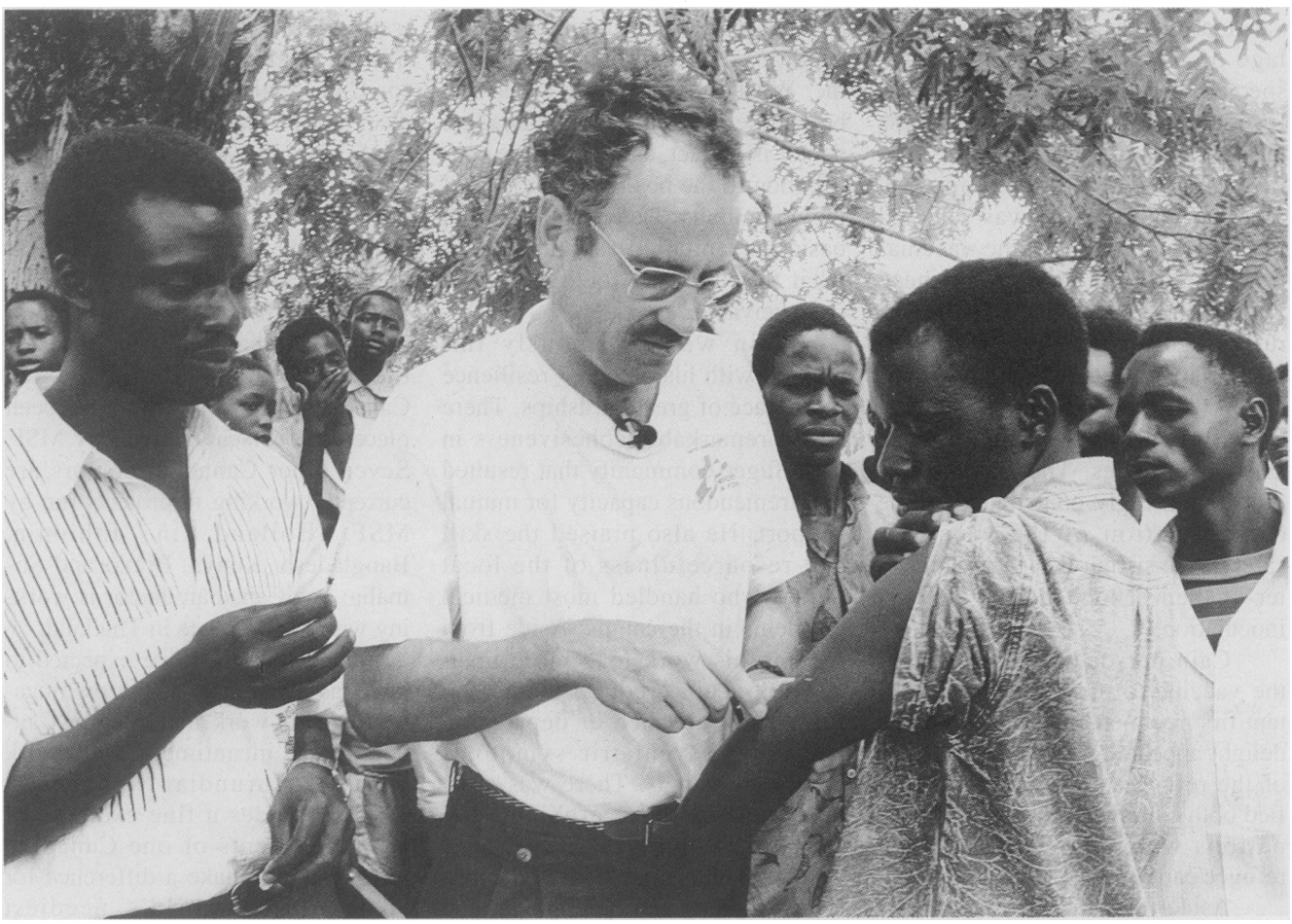
These factors all contributed to the degree of urgency felt by Cain and the other team members as their plan for a vaccination program began to take shape last year.

Forty km from the site of the MSF meeting in Bujumbura, across Lake Tanganyika in eastern Zaire, lies the town of Uvira. On its outskirts, four makeshift settlements of huts had become home to the 5000 Burundian refugees who were to be included in the planned meningitis vaccination program. In November and December 1991, in a wave of violent intolerance, the Burundian government drove an estimated 30 000 citizens into Zaire. Last fall, the last of these refugees, those most reluctant to return to Burundi, were contemplating their fate from the arid camps outside this typically colourful Zairian town.

Burundi is populated by two major tribal groups, the Tutsis and the Hutus. The government is made up almost exclusively of members of the Tutsis tribe and its policies reflect the historical enmity between the two groups. After the 1991 violence, most of the displaced Hutus returned quickly to Burundi, but several thousand others, fearing for their personal safety, were less willing to return. For months, the health status of these refugees was the responsibility of Cain and MSF, the United Nations High Commission for Refugees (UNHCR), and local health authorities.

At the meeting in Bujumbura, the planning involved a lengthy discussion of the precise way in which refugees living in Uvira would be included in the vaccination program. They were to be voluntarily repatriated, in a program sponsored by the UNHCR, following a perceptible softening of the Burundian government's hard line with respect to tribal discrimination. [Most of the refugees have now been repatriated. — Ed.]

For Cain, the problems that faced the vaccination program in Burundi were compounded by the refugees' deep-rooted mistrust of the Burundian government. Despite the apparent relaxation of tensions, the refugees believed that the government would seize any opportunity to cause them harm. A mass vaccination of the kind proposed by MSF was considered by many of the



Dr. Michael Cain administering meningitis vaccine to students in Kigoma, Zaire

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— Dr. Michael Cain

refugees to be just such an opportunity.

In true Zairian fashion, villagers had been extremely tolerant of their new refugee neighbours. However, the talk of vaccinating the refugees without offering a similar service to the locals upset some community leaders. The solution to the problem of vaccinating the reluctant refugees, and at the same time appeasing the local residents, was simple yet effective. MSF agreed to vaccinate residents in the local village of Kigoma and to invite respected community representatives from the refugee camps to witness the vaccination process.

A local school with approximately 250 students was selected for the vaccination. If the vaccinations were safe enough for these Zairian children, with whom the Burundian government has no quarrel, then this would be taken as an indication that the vaccine was not part of a Burundian government plot to kill the refugees. The school children unwittingly contributed to the demonstration of the vaccine's safety by insisting that the headmaster of their school receive the first inoculation.

Cain personally administered the vaccine to the somewhat reluctant first recipient, and the children's delight appeared to assuage the fears of the refugees. The solution satisfied both communities and the vaccinations were soon begun in the refugee camps.

Aside from the meningitis vaccination, Cain was involved in every aspect of the refugees' medical care. His duties were divided among four camps housing 5000 refugees, and he worked closely with several local nurses and had access to beds in some local hospitals.

Cain openly admits that his work involved basic medicine and problems such as malaria, gastroenteritis and respiratory tract infections, but stresses the almost symbolic importance of "being there" for the community: "These people have had to endure circumstances and conditions that are unimaginable to me. What appears on the surface to be simple medicine for a Canadian doctor is, in fact, an inestimable contribution to the health and morale of the community. Denying them such basic humanitarian assistance after what they have suffered would be inconceivable."

Cain was enormously impressed with his patients' resilience in the face of great hardships. There was a remarkable cohesiveness in the refugee community that resulted in a tremendous capacity for mutual support. He also praised the skill and resourcefulness of the local nurses who handled most medical problems in the camps. Aside from making his work load more manageable, Cain credited them with the virtual absence of depression and other psychiatric symptoms within the camps. There was great potential for these problems because of the refugees' experience with violence, loss of loved ones, loss of homes and belongings, and their limited prospects for improvement on repatriation to Burundi.

Much of MSF's work involves public health education and the training of local workers. In Uvira, Cain's efforts focused primarily on encouraging refugees to use latrines that had been properly built and maintained, and to use chlorine-treated water for drinking and washing. Despite the apparent simplicity of this advice, the community consultation needed before such actions are taken can be awkward and frustrating. His limited knowledge of Swahili helped simplify the process for Cain. Although the Swahili dialect that he learned to speak during his 5 years in Kenya is quite different from that spoken by the refugees, he was able to communicate effectively about simple matters such as the importance of sanitation.

Through his efforts in Central Africa, Cain has joined the ranks of the many talented and dedicated Canadian physicians who have been placed in overseas projects by MSF. Seven other Canadian doctors are currently working in projects run by MSF Holland in Ethiopia, Bangladesh, Kenya, Brazil and Somalia; one Canadian doctor is working with MSF France in Thailand.

These numbers are expected to grow as awareness of the organization and its work increases in Canada. In the meantime, Cain's work with the Burundian refugees in Uvira provides a fine example of how the talents of one Canadian physician can make a difference for some of the world's neediest people. ■